BEFORE THE
DEPARTMENT OF MANAGED HEALTH CARE
STATE OF CALIFORNIA

In the Matter of the Application for an Award of Advocacy and Witness Fees of: Health Access of California, a California corporation, Applicant.	**DMHC Decision 10-06-02 June 22, 2010** Application Received Date: March 16, 2010 Proceeding Control Nos. 2002-0018, 2005-0203 and 2008-1579 For 28 CCR § 1300.67.2.2 (Re: Timely Access)

DECISION GRANTING AWARD OF ADVOCACY AND WITNESS FEES TO HEALTH ACCESS OF CALIFORNIA, A CALIFORNIA CORPORATION, FOR SUBSTANTIAL CONTRIBUTION TO PROCEEDING CONTROL NOS. 2002-0018, 2005-0203 AND 2008-1579

1. SUMMARY

This decision awards Health Access of California, a California corporation ("Health Access" or "APPLICANT"), Advocacy and Witness Fees for its substantial contribution to Proceeding Control Nos. 2002-0018, 2005-0203 and 2008-1579 of the Department of Managed Health Care ("Department") regarding Timely Access ("proposed regulation"), which became final as set forth at 28 CCR §1300.67.2.2 ("regulation"). The award represents a decrease from the amount requested in order to not exceed Market Rate, for the reasons stated herein.

2. BACKGROUND OF CONSUMER PARTICIPATION PROGRAM

The Consumer Participation Program ("Program"), enacted in Health and Safety Code § 1348.9 ("Statute"), required the Director ("Director") of the Department to adopt regulations to establish the Program to allow for the award of reasonable advocacy and witness fees to any person or organization that (1) demonstrates that the person or organization represents the interests of consumers and (2) has made a substantial contribution on behalf of consumers to the adoption of any

regulation or to an order or decision made by the Director if the order or decision has the potential to impact a significant number of enrollees.

The Statute requires the regulations adopted by the Director to include specifications for: (1) eligibility of participation, (2) rates of compensation, and (3) procedures for seeking compensation. The Statute specifies that the regulations shall require that the person or organization demonstrates a record of advocacy on behalf of health care consumers in administrative or legislative proceedings in order to determine whether the person or organization represents the interests of consumers.

Pursuant to the Statute, the Program regulations were adopted as section 1010 of Title 28 of the California Code of Regulations ("Regulations"). The Regulations specify:

a. Definitions for the Program, including: "Advocacy Fee," "Compensation," "Market Rate," "Represents the Interests of Consumers," "Substantial Contribution," and "Witness Fees." (§ 1010, subsection (b)).

b. Procedure for a Request for Finding of Eligibility to Participate and Seek Compensation (§ 1010, subsection (c)), which is required to be eligible to participate in the Program.

c. Procedure for Petition to Participate (§ 1010, subsection (d)), which is required to participate in each specific proceeding.

d. Procedure for Applying for an Award of Fees. (§ 1010, subsection (e)).

3. REQUIREMENTS FOR AWARDS OF ADVOCACY AND WITNESS FEES

3.1. PROCEDURAL REQUIREMENTS

All of the following procedures must be followed and criteria satisfied for a person or organization that represents the interests of consumers to obtain a compensation award:

a. To become a "Participant," the person or organization must satisfy the requirements of either or both of the following by:

(1) Submitting to the Director a Request for Finding of Eligibility to Participate and Seek Compensation in accordance with 28 CCR §1010(c), at any time independent of the pendency of a proceeding in which the person seeks to participate, or by having such a finding in effect by having a prior finding of eligibility in effect for the two-year period specified in 28 CCR § 1010(c)(3).

(2) Submitting to the Director a Petition to Participate in accordance with 28 CCR §1010(d), no later than the end of the public comment period or the date of the first public hearing in the proceeding in which the proposed Participant seeks to become involved, whichever is later (for orders or decisions, the request must be submitted within ten working days after the order or decision becomes final).

b. The Participant must submit an "application for an award of advocacy and witness fees" in accordance with 28 CCR §1010(e), within 60 days after the issuance of a final regulation, order or decision in the proceeding.

c. The Participant must have made a Substantial Contribution to the proceeding. (Health & Saf. Code § 1348.9(a); 28 CCR § 1010(b)(8)).

d. The claimed fees and costs must be reasonable (Health & Saf. Code § 1348.9(a)) and not exceed market rates as defined in 28 CCR § 1010.

3.2. APPLICANT'S APPLICATION FOR FINDING OF ELIGIBILITY TO PARTICIPATE

On July 26, 2004, APPLICANT submitted its Request for Finding of Eligibility to Participate and Seek Compensation with the Department giving notice that it represents the interests of consumers and of its intent to claim compensation.

On or about September 10, 2004, the Director ruled that APPLICANT was eligible to participate and to seek an award of compensation.

On August 29, 2006, APPLICANT submitted its Request for [Renewal] of Finding of Eligibility to Participate and Seek Compensation in the CPP, giving notice that it represents the interests of consumers and of its intent to claim compensation.

By email dated September 21, 2006, notice was given that APPLICANT's Request for [Renewal] of Finding of Eligibility to Participate and Seek Compensation was approved.

On October 15, 2008, APPLICANT submitted its Request for [Renewal] of Finding of Eligibility to Participate and Seek Compensation in the CPP, giving notice that it represents the interests of consumers and of its intent to claim compensation.

By letter dated December 14, 2009, Notice of Ruling on Request for Renewal of Finding of Eligibility to Participate and Seek Compensation was given that the APPLICANT was eligible to participate in the CPP and to seek an award of compensation.

3.3. APPLICANT'S PETITION TO PARTICIPATE IN THE TIMELY ACCESS PROCEEDING

On October 1, 2004, APPLICANT submitted its Petition to Participate (Petition) in the Timely Access rulemaking proceeding. In its Petition, APPLICANT estimated its fees to be $25,000.00.

On or about October 29, 2004, the Director approved APPLICANT's Petition to Participate in the Timely Access rulemaking proceeding.

3.4. APPLICATION FOR AWARD OF ADVOCACY AND WITNESS FEES

The regulation became final and effective on January 17, 2010. Within 60 days thereafter (on March 16, 2010), APPLICANT timely submitted its Application for an Award of Advocacy and Witness Fees (Application). 28 CCR § 1010(e)(1).

After the Application was publicly noticed, no objections to the Application were received.

The application for an award of compensation must include (as required by 28 CCR § 1010(e)(2) and (3)):

> "a. A detailed, itemized description of the advocacy and witness services for which the Participant seeks compensation;
> b. Legible time and/or billing records, created contemporaneously when the work was performed, which show the date and the exact amount of time spent[1] on each specific task;[2] and
> c. A description of the ways in which the Participant's involvement made a Substantial Contribution to the proceeding as defined in subpart (b)(8), supported by specific citations to the record, Participant's testimony, cross-examination, arguments, briefs, letters, motions, discovery, or any other appropriate evidence." 28 CCR §1010 (e)(2).

With its Application, APPLICANT submitted a billing specifying the dates of services, a description of each specific task or each activity of advocacy and witness service, identification of the person providing each service, the elapsed time (exact amount of time spent) for each service in 0.5 hour or 30 minute increments for non-attorney advocates, the hourly rate requested,[3] and the total dollar amount billed for each task. The application did not include billing for attorney advocates. The total fees requested for work performed by APPLICANT is $142,510.00.

The Hearing Officer finds that the Application of APPLICANT substantially complies with the technical requirements of 28 CCR § 1010(e)(2) and (3).

4. PROCEDURAL HISTORY

The evolution of the Timely Access proceeding consisted of informal stakeholders meetings and three noticed proceedings with three proceeding control numbers identified as follows.

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[1] "...the phrase 'exact amount of time spent' refers either to quarters (15 minutes) of an hour for attorneys, or to thirty (30) minute increments for non-attorney advocates." 22 CCR § 1010(e)(3).

[2] "The phrase 'each specific task,' refers to activities including, but not limited to:

a. Telephone calls or meetings/conferences, identifying the parties participating in the telephone call, meeting or conference and the subject matter discussed;

b. Legal pleadings or research, or other research, identifying the pleading or research and the subject matter;

c. Letters, correspondence or memoranda, identifying the parties and the subject matter; and

d. Attendance at hearings, specifying when the hearing occurred, subject matter of the hearing and the names of witnesses who appeared at the hearing, if any." 28 CCR § 1010(e)(3)a, b, c, and d.

[3] Under the PUC Intervenor Compensation Program, the intervenors submit time logs to support the hours claimed by their professionals. Those logs typically note the dates, the number of hours charged, and the issues and/or activities in which each was engaged. D.06-11-009 (November 9, 2006), p. 26.

4.1. PROCEEDING CONTROL NO. 2002-0018 – Access to Needed Health Care Services, amending section 1300.67.2 and adopting sections 1300.67.2.2 and 1300.67.2.3 in title 28, California Code of Regulations

On July 9, 2004, the Department issued a Notice of Proposed Rulemaking proposing to amend 28 CCR section 1300.67.2, adopt 28 CCR sections 1300.67.2.2 and 1300.67.2.3, and establishing a 45-day comment period from July 9, 2004 to August 23, 2004.

Initially, no public hearing was scheduled on the proposed regulations.

In the Informative Digest/Policy Statement Overview contained within the Notice of Proceeding Control No. 2002-0018, the Department stated that:

> "California Health and Safety code sections 1344 and 1346 vest the Director with the power to administer and enforce the provisions of the Act.
>
> California Health and Safety Code section 1344 mandates that the Director have the ability to adopt, amend, and rescind such rules, forms, and orders as are necessary to carry out the provisions of this chapter, including rules governing applications and reports, and defining any terms, whether or not used in this chapter, insofar as the definitions are not inconsistent with the provisions of the Act. Furthermore, the Director may waive any requirement of any rule or form in situations where in the Director's discretion such requirement is not necessary in the public interest or for the protection of the public, subscribers, enrollees, or persons or plans subject to this chapter. In addition, the Director may honor requests from interested parties for interpretive opinions.
>
> California Health and Safety Code section 1346 vests in the Director the power to administer and enforce the Act, including but not limited to recommending and proposing the enactment of any legislation necessary to protect and promote the interests of plans, subscribers, enrollees, and the public.
>
> Health and Safety Code section 1367.03 requires the Department to develop and adopt regulations to ensure that enrollees have timely access to needed health care services. The Director proposes amending section 1300.67.2 and adopting sections 1300.67.2.2 and 1300.67.2.3 in Title 28, California Code of Regulations to effectuate section 1367.03 by setting forth minimum standards with which health care service plans (plans) shall comply to ensure that enrollees have timely access to needed health care services.
>
> The proposed regulations set access to care standards concerning the availability of primary care physicians, specialty care physicians, hospital care, and other specified health care services to ensure that enrollees have timely access to care.
>
> Amending section 1300.67.2 and adopting sections 1300.67.2.2 and 1300.67.2.3 shall benefit enrollees because it will ensure that plans provide health care services within reasonable proximity of the business or residence of the enrollee including accessible emergency health care services. The

regulation clarifies that all services offered by the plan be accessible without delays detrimental to the health of the enrollees and set timelines for routine non-urgent care, urgent care and preventive care. This will ensure that plan enrollees will receive needed health care services within a reasonable timeframe, while not be overburdening the plans or providers."

A Public Hearing on the proposed regulation was scheduled, noticed for, and held on August 16, 2004.

On August 17, 2004, the Department issued an Amended Notice of Proposed Rulemaking proposing to amend 28 CCR section 1300.67.2, adopt 28 CCR sections 1300.67.2.2 and 1300.67.2.3, and extending the public comment period for 30 days to September 22, 2004.

The Department requested input regarding the proposed regulations at a stakeholder meeting held on September 13, 2004, in order to increase public participation and improve the quality of the proposed regulation. Gov't Code § 11346.45. Notes regarding comments provided at the meeting were included in the record of the proceedings.

On September 15, 2004, the Department issued an Amended Notice of Proposed Rulemaking proposing to amend 28 CCR section 1300.67.2, adopt 28 CCR sections 1300.67.2.2 and 1300.67.2.3, and extending the public comment period for 45 days to November 8, 2004.

The Department requested input regarding the proposed regulations at a stakeholder meeting held on October 20, 2004, in order to increase public participation and improve the quality of the proposed regulation. Gov't Code § 11346.45. Notes regarding comments provided at the meeting were included in the record of the proceedings.

On April 1, 2005, the Department issued a Notice of a Second Public Comment Period for 15 days ending April 22, 2005, regarding the proposed regulation modified as a result of comments received in the prior 120-day comment period.

By letter dated April 19, 2005, the Department gave notice of intention to withdraw the proposed regulations from the proceeding and to propose a revised version of the regulations pursuant to a new rulemaking proceeding. A formal Notice of Decision Not To Proceed was published on April 29, 2005.

4.2. PROCEEDING CONTROL NO. 2005-0203 -- Timely Access To Health Care Services, adopting section 1300.67.2.2 in title 28, California Code of Regulations

Beginning in October of 2006, the Department invited parties who would be the subject of the proposed regulation to public discussions ("stakeholder meetings") in order to increase public participation and improve the quality of the proposed regulation. Gov't Code § 11346.45. Stakeholder meetings were held during October and November of 2006.

On January 12, 2007, the Department issued a Notice of Proposed Rulemaking and Notice of Public Hearing proposing to adopt 28 CCR section 1300.67.2.2, establishing a 52-day written comment period from January 12, 2007 through March 5, 2007, and scheduling a public hearing to be held on March 5, 2007. A Public Hearing was held on March 5, 2007.

In the Informative Digest/Policy Statement Overview contained within the Notice of Proceeding Control No. 2005-0203, the Department stated that:

> "The Department proposes to adopt section 1300.67.2.2 pursuant to California Health and Safety code section 1367.03, which specifically authorizes the Department to develop and adopt regulations to ensure that enrollees have access to needed health care services in a timely manner. Section 1367.03 directs the Department to develop indicators of and standards for timeliness of access to care.
>
> AB 2179 (2002) added section 1367.03 of the Health and Safety Code, expressly instructing the Department to develop and adopt regulations to assure timely access to health care. The statute also contained specific requirements for the content of the regulations, including requirements that the regulations establish indicators of timeliness of access to care, adopt standards for timely access to health care services, and specify the manner in which health care service plans are to report annually to the Department on compliance with the standards. Accordingly, the regulation establishes standards and requirements related to: timely access to primary care physicians, specialty physicians, hospital care, and other health care; health plan monitoring of health care provider compliance with the standards; corrective action by health plans upon identifying deficiencies in compliance; and the statutory requirement of filing an annual report of compliance.
>
> The statute requires the adoption of "time elapsed" standards specifying the time elapsed between the time an enrollee seeks health care and obtains care. The statute also authorizes the Department to adopt standards other than time elapsed but requires the Department to demonstrate why such standard other than time elapsed is "more appropriate." Proposed section 1300.67.2.2 adopts time elapsed standards and proposes a "same-day access" standard which is demonstrated to be "more appropriate" than time elapsed standards because timeliness of access under the same-day access standard exceeds timeliness of access under all of the time elapsed standards of the proposed regulation.
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> In Section 1 of AB 2179, the Legislature found and declared 'that timely access to health care is essential to safe and appropriate health care and that lack of timely access to health care may be an indicator of other systemic problems such as lack of adequate provider panels, fiscal distress of a health care service plan or a health care provider, or shifts in the health needs of a covered population.'"

On July 16, 2007, the Department issued a Notice of a Second Public Comment Period for 45 days from July 16, 2007 through August 30, 2007, and Notice of Second Public Hearing for August

13, 2007. By notice dated August 8, 2007, the Department rescheduled the Second Public Hearing to September 18, 2007, and extended the Second Public Comment Period for 21days ending September 21, 2007. A Public Hearing was held on September 18, 2007.

On December 10, 2007, the Department issued a Notice of a Third Public Comment Period for 16 days from December 10, 2007 through December 26, 2007.

On January 11, 2008, the Department submitted the proposed regulation to the Office of Administrative Law ("OAL") for review in accordance with the Administrative Procedure Act ("APA"). On February 27, 2008, the OAL disapproved the proposed regulation and issued a Decision of Disapproval of Regulatory Action dated March 5, 2008.

4.3. PROCEEDING CONTROL NO. 2008-1579 – Timely Access to Non-Emergency Health Care Services, adopting section 1300.67.2.2 in title 28, California Code of Regulations

In June and September of 2008, the Department invited parties who would be the subject of the proposed regulation to public discussions ("stakeholder meetings") in order to further increase public participation and improve the quality of the proposed regulation. Gov't Code § 11346.45.

On January 9, 2009, the Department issued a Notice of Proposed Rulemaking Action proposing to adopt 28 CCR section 1300.67.2.2, and establishing a 45-day comment period from January 9, 2009 to February 23, 2009.

In the Informative Digest/Policy Statement Overview contained within the Notice of Proceeding Control No. 2008-1579, the Department stated that:

> "The Department proposes to adopt section 1300.67.2.2 to establish standards and requirements for timely access as required by section 1367.03.
>
> AB 2179 (2002) added section 1367.03 of the Health and Safety Code, directing the Department to develop and adopt regulations to ensure that enrollees have timely access to needed health care services. In Section 1 of AB 2179 the Legislature found and declared "that timely access to health care is essential to safe and appropriate health care and that lack of timely access to health care may be an indicator of other systemic problems such as lack of adequate provider panels, fiscal distress of a health care service plan or a health care provider, or shifts in the health needs of a covered population."
>
> Section 1367.03 contains a number of requirements regarding the development and content of the regulations, including specified factors to be considered by the Department in developing the regulations, requirements for contracts between plans and providers, and annual plan reporting requirements. The proposed regulations have been developed in accordance with the legislative directive set forth in Section 1367.03.

> These proposed regulations adopt a balanced approach, to achieve workability and provide for operational flexibility, by establishing both performance standards and prescriptive time-elapsed standards; reasonable mechanisms to preserve the relevance of the clinical judgment of providers, provisions to encourage best practices for enhanced accessibility and a mechanism for enrollees to obtain assistance in determining the relative urgency of their need an appointment. These proposed regulations also strike a reasonable balance with meaningful performance standards for quality assurance monitoring by plans and their delegated provider groups."

Initially, no public hearing was scheduled on the proposed regulations. However, by letter dated January 28, 2009, a representative of the California Medical Association requested that a public hearing be held.

On January 30, 2009, the Department issued an Amended Notice of Rulemaking Action and Public Hearing Agenda. The Public Hearing was scheduled for and held on February 23, 2009.

On June 10, 2009, the Department issued a Notice of Second Comment Period and modified Proposed Text for 15 days from June 10, 2009 through June 25, 2009.

On July 23, 2009, the Department issued a Notice of Third Comment Period and modified Proposed Text for 15 days from July 23, 2009 through August 7, 2009.

On September 28, 2009, the Department issued a Notice of Fourth Comment Period and modified Proposed Text for 15 days from September 28, 2009 through October 13, 2009.

On or about November 3, 2009, the Department issued an Updated Informative Digest for Timely Access to Non-Emergency Health Care Services (2008-1579) as follows:

> "As required by section 11346.9 of the Government Code, the Director of the Department of Managed Health Care (Director) sets forth below the updates to the Informative Digest for this rulemaking action proposing the addition of section 1300.67.2.2 to title 28, California Code of Regulations (Regulations).

Authority and Reference

> Pursuant to Health and Safety Code section 1341.9, the Department of Managed Health Care (Department) is vested with all duties, powers, purposes, responsibilities, and jurisdiction as they pertain to health care service plans (plans) and the health care service plan business.
>
> Health and Safety Code section 1344 grants the Director authority to adopt, amend, and rescind such rules, forms, and orders as are necessary to carry out the provisions of the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act).
>
> Health and Safety Code section 1367.03, added to the Knox-Keene Act pursuant to AB 2179, (stats 2002, c. 797) requires the Department to develop and adopt regulations to ensure that enrollees have access to needed health care

services in a timely manner by developing indicators of timeliness of access to care and developing standards for timeliness of access.

Health and Safety Code section 1367 establishes significant standards for the delivery and quality of health care services by health plans, including broad requirements for delivering care in a timely manner as appropriate for each enrollee's health care needs, and consistent with good professional practice. Subsection (d) of section 1367 requires that plans "shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice." Prior to the enactment of AB 2179, subsection (e)(1) of section 1367 required that "All services shall be readily available at reasonable times to all enrollees. To the extent feasible, the plan shall make all services readily accessible to all enrollees." AB 2179 amended subsection (e)(1) to require, "All services shall be readily available at reasonable times to each enrollee consistent with good professional practice. To the extent feasible, the plan shall make all services readily accessible to all enrollees consistent with Section 1367.03." (Underline added to reflect the new language added by AB 2179.)

AB 2179 made another notable amendment to section 1367, by adding the following clarification regarding the ultimate obligation of health plans to comply with the standards and requirements of section 1367, "The obligation of the plan to comply with this section shall not be waived when the plan delegates any services that it is required to perform to its medical groups, independent practice associations, or other contracting entities."

Health and Safety Code section 1367.01, regarding health plan utilization review processes, and Civil Code section 3428, establishing a cause of action for ordinary negligence for a health plan's breach of the duty of ordinary care in performing utilization review, are important provisions relevant to the development of these regulations.

Necessity

Adoption of Section 1300.67.2.2 remains necessary to implement, clarify, and make specific the requirements of Health and Safety Code section 1367.03 (Section 1367.03) as described in the initial Notice of Rulemaking Action published on January 9, 2009. As explained in the Department's Notice of Rulemaking Action and the Initial Statement of Reasons, Section 1367.03 expressly instructs the Department to develop and adopt regulations "to ensure that enrollees have access to needed health care services in a timely manner" and directed the Department to develop indicators of timeliness of access to care including three indicators specified in subsection (a)(1)-(3) of Section 1367.03. Subsection (b) of Section 1367.03 further directs the Department to consider specified factors in developing standards for timeliness of access to care. Subsection (c) of Section 1367.03 permits the Department to adopt standards other than the time-elapsed from the time an enrollee first seeks care and obtains it, if the Department demonstrates why that standard is more appropriate.

AB 2179 also required the California Department of Insurance (CDI) to adopt regulations, although the legislature described a different approach for the CDI than it outlined for the Department. The Department has consulted with CDI regarding the development of these regulations, consistent with Section 1342.4, to assess the potential for consistency in developing the respective regulations.[4]

The course of this rulemaking action has been highly complex and controversial, with interested and affected persons very polarized in their views about the best approach to establish standards for timeliness of access to health care services. The extreme complexity and serious polarization of the interested persons participating in the development of this regulation resulted in the submission of many different alternatives by the interested persons. The alternatives proposed to and considered by the Department are captured in the public comments collected during four public comment periods, and in the Department's responses to each of the public comments.

The final revised regulation text remains true to the legislative intent and mandate reflected in Section 1367.03, while accomplishing the difficult task delegated to the Department by the Legislature, that is, to balance the competing concerns among affected persons, to accomplish sensible, workable and meaningful regulations designed to ensure timely access to care for enrollees. The necessity for the provisions in the final revised text and for the changes made to the text that was initially published, is explained in the Final Statement of Reasons.

The final revised regulation text reflects substantial changes that are sufficiently related to the original text and within the scope of the Notice of Rulemaking Action. Accordingly, consistent with APA requirements, the Department made the revised text available for public comment. A reasonable member of the directly affected public could have determined from the Notice that these changes to the regulation could have resulted."

On November 3, 2009, the final regulation package was submitted to the Office of Administrative Law (OAL). The regulation was approved by OAL[5] and filed with the Secretary of State on December 18, 2009. The regulation was effective on January 17, 2010.[6]

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[4] The CDI added geographic accessibility standards (distance metrics) to its existing regulations. The geographic access standards added by the CDI for primary care physicians and hospitals are consistent with the Department's geographic access standards for those categories of services. The CDI also added geographic access standards for specialist physicians and mental health care providers. These regulations do not modify existing Knox-Keene geographic access standards, which do not include standards for specialist physicians and mental health care providers. The Department's approach, as required by Section 1367.03, is directed to address the waiting times for services. Sections 1300.51(d)(Exhibit H), 1300.67.2 and 1300.67.2.1, title 28, California Code of Regulations. Additional consistency between CDI regulations and DMHC regulations may be found in physician-to-enrollee ratio requirements: one full time equivalent primary care physician for every 2000 enrollees; and one full time equivalent physician for every 1,200 enrollees.

[5] Office of Administrative Law, Notice of Approval of Regulatory Action, OAL File No. 2009-1103-04 S, December 18, 2009.

5. SUBSTANTIAL CONTRIBUTION

Health and Safety Code section 1348.9, subdivision (a) provides that:

> "[T]he director shall adopt regulations to establish the Consumer Participation Program, which shall allow for the director to award reasonable advocacy and witness fees to any person or organization that demonstrates that the person or organization represents the interests of consumers and has made a substantial contribution on behalf of consumers to the adoption of any regulation...." (Emphasis added).

The definition of "Substantial Contribution" provides the criteria for evaluating whether the Participant has made a Substantial Contribution.[7] 28 CCR § 1010(b)(8) defines "Substantial Contribution" as follows:

> "'Substantial Contribution' means that the Participant significantly assisted the Department in its deliberations by presenting relevant issues, evidence, or arguments which were helpful, and seriously considered, and the Participant's involvement resulted in more relevant, credible, and non-frivolous information being available to the Director."

5.1 APPLICATION MUST INCLUDE DESCRIPTION OF CONTRIBUTION

The application for an award of compensation must include "a description of the ways in which the Participant's involvement made a Substantial Contribution to the proceeding [8]...,

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[6] *Id.*

[7] Further guidance is provided in PUC Decisions awarding intervenor compensation – for example:

> "In evaluating whether ... [an intervenor] made a substantial contribution to a proceeding, we look at several things. First, did the ALJ or Commission adopt one or more of the factual or legal contentions, or specific policy or procedural recommendations put forward by the ... [intervenor]? ... Second, if the ...[intervenor's] contentions or recommendations paralleled those of another party, did the ...[intervenor's] participation materially supplement, complement, or contribute to the presentation of the other party or to the development of a fuller record that assisted the Commission in making its decision? ... [T]he assessment of whether the ...[intervenor] made a substantial contribution requires the exercise of judgment.
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> "In assessing whether the ...[intervenor] meets this standard, the Commission typically reviews the record, ... and compares it to the findings, conclusions, and orders in the decision to which the ...[intervenor] asserts it contributed. It is then a matter of judgment as to whether the ..[intervenor's] presentation substantially assisted the Commission. [citing D.98-04-059, 79 CPUC2d 628, 653 (1998)].
>
> Should the Commission not adopt any of the ...[intervenor's] recommendations, compensation may be awarded if, in the judgment of the Commission, the ...[intervenor's] participation substantially contributed to the decision or order. For example, if ...[an intervenor] provided a unique perspective that enriched the Commission's deliberations and the record, the Commission could find that the ...[intervenor] made a substantial contribution." PUC Decision D.06-11-031 (November 30, 2006), PP. 5 - 6; similarly, D.06-11-009 (November 9, 2006), pp. 7 - 8.

[8] Decisions under the PUC's Intervenor Compensation Program go further and require intervenor's to assign a reasonable dollar value to the benefits of the intervenor's participation.

> "D.98-04-059 directed ...[intervenors] to demonstrate productivity by assigning a reasonable dollar value to the benefits of their participation to ratepayers. The costs of ...[an intervenor's] participation

supported by specific citations to the record, Participant's testimony, cross-examination, arguments, briefs, letters, motions, discovery, or any other appropriate evidence." 28 CCR § 1010(e)(2)c.

5.2. APPLICANT'S DESCRIPTION OF ITS CONTRIBUTION

APPLICANT submitted the following information, documents and testimony in support of its position regarding the proposed adoption of the proposed regulation and regulation changes:

> Health Access' Unique Contribution to Timely Access ... did the following things:
> • We were the organization that sponsored the original legislation, working with interested parties to craft the measure in 2003.
> • We have been the primary proponent of time-elapsed standards as the measure of timely access. This was the approach adopted by the Department in its deliberations.
> • Our questions and probing prompted the discovery that each health care service had been filing its own self-defined time-elapsed standards since the creation of Knox-Keene in 1975 but the plans had no means of demonstrating compliance with those standards. We also prompted the Department to compare the pre-existing, self-imposed time-elapsed standards of the major health care service plans, revealing substantial consistency among these standards.
> • We helped to craft the enforcement approach, making a vigorous case that consumer satisfaction surveys alone are not sufficient and that other scientifically valid means of determining compliance were necessary and appropriate.
> • We contributed significantly to the standard for triage, providing the policy rationales of reducing emergency room crowding and assuring clinically appropriate timely care when a consumer needs assistance in determining whether they are facing an emergency or can wait until the next day to obtain care.
> • We also provided the policy argument that meaningful timely access standards should reduce inappropriate emergency room utilization by persons with coverage, thus relieving worsening emergency room crowding.
> • We contributed significantly to the provisions of the regulation that provide an assessment of existing network adequacy. We also were the primary proponents of revisiting and making meaningful the existing regulation on the ratio of primary care physicians to enrollees. The department did not adopt our proposal but did include provisions that will allow the department greater capacity to determine network adequacy.

Applicant submitted the following supporting documents to support its description of Substantial Contribution:

> Health Access Supporting Document 3-5-07
> Health Access Supporting Document 9-21-07
> Health Access Supporting Document 12-26-07
> Health Access Supporting Document 8-22-08
> Health Access Supporting Document 11-25-08
> Health Access Supporting Document 2-23-09pt1
> Health Access Supporting Documents 2-23-09pt2

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should bear a reasonable relationship to the benefits realized through their participation. This showing assists us in determining the overall reasonableness of the request." D.06-11-031 (November 30, 2006), p. 11; D.06-11-009 (November 9, 2006), pp. 31 - 32.

Health Access Supporting Document 6-24-09
Health Access Supporting Documents 8-7-09
Health Access Supporting Documents 10-12-09
Health Access Supporting Documents 1-20-10

5.3 PROCEDURAL VERIFICATION OF SUBSTANTIAL CONTRIBUTION

Proceeding Control No. 2002-0018

In preparation for submitting comments, APPLICANT's staff reviewed the Notice of Proposed Rulemaking and the language of the proposed regulation.

On August 16, 2004, the Executive Director of APPLICANT testified at a Public Hearing on the proposed regulation.

Following the Public Hearing, APPLICANT's staff apparently prepared, revised and edited written comments on the proposed regulation. The initial public comment period would have expired on August 23, 2004, but was extended to September 22, 2004, and extended again to November 8, 2004. By letter dated December 7, 2004 and received by the Department on December 13, 2004, well after the extended period for public comments had closed on November 8, 2004, APPLICANT submitted written comments. Although APPLICANT's comment letter, dated December 7, 2004, was not timely received during the first public comment period ending November 8, 2004, the comments were received prior to the close of the second public comment period noticed to close on April 22, 2005.

Of the August 16, 2004, public hearing comments and the comments of the letter dated December 7, 2004, all were reviewed and considered, but all were neither accepted nor declined because the Department issued notice of its decision not to proceed with the rulemaking action of Proceeding Control No. 2002-0018.

On June 17, 2005, representatives of APPLICANT participated in a stakeholder meeting with the Department to discuss the future of timely access regulations.

APPLICANT's representatives participated in stakeholder meetings conducted by the Department in October and November 2006, in order to improve the quality of provisions to be included in a timely access regulation to be proposed. APPLICANT's representatives prepared key areas of concern and outlined questions and concerns to present to the Department. In preparation for participation in the stakeholder meetings, APPLICANT's representatives reviewed a document distributed by the Department on proposed timely access to care regulation provisions, previous oral testimony and written comments, comparative standards of the top seven health plans, and the timely access Statute.

On March 5, 2007, a Health Care Policy Expert and Project Director of APPLICANT testified at a Public Hearing on the proposed regulation. Other representatives of APPLICANT prepared and edited draft comments for presentation at the Public Hearing.

By letter dated March 5, 2007, APPLICANT's staff presented written comments on the proposed regulation, signed by the Executive Director of APPLICANT. That submission contained approximately ten comments, including expressions of support for certain provisions and presentation of analysis of hypothetical fact situations illustrating why the provisions were needed. Eight of the comments contained recommendations requesting changes (identified below in the order presented in the comment letter).

(1) Low English-proficient consumers should be entitled to timely access to care and care should be delivered in a language that the patient can understand. Consumers should not have to choose between linguistic access and timely access to care. There are numerous alternatives that would help providers meet each of these imperatives in a cost-effective manner, including Video Medical Interpretation.

(2) There is no statutory basis for the following sentence, which contradicts legislative history, and should be stricken: "This section is not intended to create any basis for an individual cause of action not presently existing in law and is not intended to apply to emergency medical conditions and emergency care which are regulated and governed by other applicable law including Health and Safety Code section 1317.1."

(3) The proposed regulation should reflect non-waiver when the plan delegates any services it is required to perform to medical groups, independent practice associations, or other contracting entities.

(4) Plans' failure for three decades to comply with their own timely access standards indicates what the statute and proposed regulation should remedy.

(5) Provisions of the proposed regulation that provide for telephone access within 30 minutes should be amended to 15 minutes so as not to use up half of the "golden hour" (prompt response to life-threatening conditions). Waiting for triage is bad care. The intent of the Knox-Keene Act is to assure that consumers can receive care when they need it.

(6) Regarding "alternative standards," "provider availability" should be substituted for "provider shortage." In addition, "clinical appropriateness" should be added as justification for a proposed alternative standard. Renewal of alternative standards should be through a material

modification filing, to assure compliance with the timely access standards and require review of any complaints about lack of timely access and other indications of lack of clinically appropriate care.

(7) Regarding enrollee satisfaction surveys, the questions asked must be publicly available documents (CAHPS survey questions are not public available documents).

(8) There is no statutory basis for specifying that the proposed regulation does not create a new cause of action, and it should be stricken.

On September 18, 2007, a Health Care Policy Expert and Project Director of APPLICANT testified at a Public Hearing on the proposed regulation. In addition to the Project Director, other representatives of APPLICANT prepared and edited draft comments for presentation at the Public Hearing.

By letter dated September 21, 2007, APPLICANT's staff presented written comments on the proposed regulation, signed by the Executive Director of APPLICANT. That submission contained approximately eight comments, including expressions of support for certain provisions and presentation of analysis of hypothetical fact situations illustrating why the provisions were needed. The submission contained comments with recommendations requesting changes (identified below in the order presented in the comment letter).

(1) Specific time-elapsed standards would be the only mechanism to ensure the goal of timely access to health care. The statute provides that the Department may choose a standard other than time-elapsed standards if the Department demonstrates why that standard is more appropriate. No one has demonstrated that any other standard is more appropriate in terms of meeting the obligations of the Knox-Keene Act. The suggestion by health plans and associations that the Department begin the regulation process again is completely without merit and is directly contrary to statutory obligation of the Department to complete the timely access regulation no later than January 1, 2004.

(2) Language providing an open-ended exemption from compliance with timely access standards in provider shortage situations could make meaningless all of the other requirements of these regulations. The exemption does nothing to set timelines or force other action such as withdrawal from a geographic region where the plan is unable to provide timely access or refusal of permission to add covered lives. The failure to provide timely care and an adequate network merits enforcement action. Section 1367.03(d) gives the Department no statutory authority to exempt plans from standards on timeliness of access. Instead, the Legislature made plain that the Department could only return to the Legislature for further action, and the Department lacks statutory authority to grant exemptions due to provider shortages.

(3) Telephone triage is care which must be governed by a "standard," not a "guideline." All health plans and all contracting providers should be required to provide prompt telephone service during business hours and telephone triage after hours. Plans and providers should provide access to telephone triage 24 hours a day, seven days a week, rather than sending consumers to overcrowded emergency rooms.

(4) We reassert that low English-proficient consumers should be entitled to timely access to care and care should be delivered in a language that the patient can understand. Consumers should not have to choose between linguistic access and timely access to care. There are numerous alternatives that would help providers meet each of these imperatives in a cost-effective manner, including Video Medical Interpretation.

(5) The provision for plans to propose alternatives to the timely access standards appears to enable a plan to adopt an alternative more lenient standard that could last for years. Proposed alternatives should be assessed as to whether they are more appropriate for the consumer. Objection is made to using the material modification as the approval mechanism because the material modification is an internal procedure not open to public comment or scrutiny and would potentially enable plans to evade their responsibility to meet the timely access standards.

(6) In addition to plan oversight and verification of provider compliance with timely access standards, the Department should undertake to verify the reliability of information supplied by health plans when there is reason to question its validity, credibility, or veracity, or when the Department otherwise believes that additional verification is appropriate.

(7) Regarding compliance monitoring, non-anonymous surveying should not be permitted because it is not a valid indicator of access to care.

(8) The standard for timely access to urgent mental health care should be 24 hours instead of 48 hours.

By letter dated December 26, 2007, APPLICANT's staff presented written comments on the proposed regulation, signed by the Executive Director of APPLICANT. APPLICANT expressed "...surprise and dismay at the Department's complete abandonment of the statutory intent of AB 2179 ...[because] the language contained in the third version of the proposed regulation reflects virtually none of the essential standard-setting, compliance oversight, and enforcement remedies outlined in the law and the first and second versions of the regulation." In addition, APPLICANT's letter stated: "It is now apparent with this third revision of the regulation that the Department has capitulated to industry pressure. ... In fact, ... we can find no rationale for DMHC's December 2007 version of the regulation that proposes weak standards, multiple exceptions to those standards, and

relies heavily upon self-regulation by the plans. The flexibility built into this version of the regulation would make it unlikely that the Department would undertake vigorous enforcement of timely access standards." APPLICANT's submission contained approximately eleven comments, including the following (identified in the order presented in the comment letter).

(1) The December version of the proposed regulation "... is so flawed that the only acceptable course of action would be to withdraw this language, and adopt the second version with the revisions described in our September 21, 2007 letter. The fact that the current version of the regulation consists of seven pages, as opposed to 25 pages in the previous version, we believe it reflects generally less specificity, fewer requirements, and vaguer standards."

(2) The Department should "... reinstate the timely access to care standard as envisioned in the language of the legislation." "[T]he provision ... allowing each plan to develop their own timely access to care standard constitutes the establishment of **no standard at all.**" "Therefore, ... specific time-elapsed standards ... would be the only mechanism for the Department to ensure its stated goal of timely access to health care."

(3) The Statute gives the Department no authority to exempt specialized plans from the standards of timeliness of access. Timely access standards must apply to all health plans.

(4) Regarding standards for telephone triage, all plans and all contracting providers should be required to provide prompt telephone service during business hours and telephone triage after hours. Timely access to care requires that consumers, who are not clinicians, have access to a health care professional who is trained to screen and refer them for emergency or urgent care when appropriate or simply to assure them that they can safely wait until the morning to be seen. Telephone triage is care, and by definition, the first effort by an enrollee to seek care. Therefore, telephone triage must be governed by a "standard," not a "guideline."

(5) The provision that timely access does not create a new cause of action should be stricken because it has no statutory basis and contradicts the legislative history.

(6) Regarding meaningful standards for enrollee satisfaction surveys, the questions asked must be in a publicly available document. The CAHPS[9] or ECHO[10] survey instruments are only

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[9] The **Consumer Assessment of Healthcare Providers and Systems** (CAHPS) program is a public-private initiative to develop standardized surveys of patients' experiences with ambulatory and facility-level care.

[10] ECHO stands for **Experience of Care and Health Outcomes**. This name was selected in order to

- Differentiate this instrument from previous questionnaires (specifically, CABHS, which was the Consumer Assessment of Behavioral Health Services survey);
- Capture what the survey actually measures; and
- Allow those administering the survey to maintain patients' privacy by not explicitly revealing its focus on behavioral health services.

available at considerable cost and are not subject to either the open meetings law or the Public Records Act.

(7) The material modification mechanism for approval of a deviation from timely access requirements should not be used because it is not open to public comment or scrutiny. It would potentially enable plans that will not or cannot meet the timely access standards to evade their responsibility.

(8) The proposed regulation should give consideration to adequacy of plan networks. Instead, time-elapsed standards have been significantly weakened while enrollee-to-provider ratios have also been eliminated, risking plan inability to provide adequate access to care.

(9) The proposed regulation should not continue with an open-ended exemption from compliance with timely access standards in provider shortage situations, especially without explanation of the efforts the plan has undertaken to remedy the shortage of providers.

(10) The exemption from adherence to timely access standards by virtue of offering advanced access is overly broad. Plans would not be able to deliver on open-ended promises of advanced access for all enrollees to all providers in all jurisdictions.

(11) Timely access to care should be reflected on the Office of the Patient Advocate (OPA) Report Card based on concrete, standardized measurement of timely access performance.

Of the March 5, 2007, September 21, 2007, and December 26, 2007, comments requesting changes, all were reviewed, but all were neither accepted nor declined because the OAL, by decision dated March 5, 2008, disapproved the newly proposed regulation, and the Department did not proceed further with the rulemaking action of Proceeding Control No. 2005-0203.

From June to September 2008, representatives of APPLICANT participated in stakeholder meetings to help shape the future of the timely access regulations.

APPLICANT's participation in the informal stakeholder process included comments provided by letter dated August 22, 2008. That submission contained approximately twelve comments, prefaced by the following:

> "[W]e can find no rationale whatsoever for DMHC to draft a regulation that proposes weak standards, allows multiple exceptions to those standards, or relies upon self-regulation by the plans. The force of the industry's opposition to timely access should dictate the need for the Department to write a regulation to provide a clear mandate, establish an unequivocal standard, undertake vigorous enforcement, and preserve greater protections for the enrollees as intended by the statute, rather than the reverse."

In addition to the chart requested from all stakeholders in this informal process, APPLICANT prepared a statement of principles that APPLICANT argued should reflect the goals of the

Department and govern the standards and language of the timely access regulation that is ultimately adopted. The principles are as follows, and the letter included supporting argument and information.

(1) The regulation should reflect specific and appropriate industry-wide, time-elapsed standards as the only measurement of the goal of timely access.

(2) Timely access standards must apply to all health plans including specialized plans. There is no statutory authority to exempt plans from standards on timeliness of access.

(3) Consumers should not have to make a choice between cultural and linguistic access to care and their right to timely access to care.

(4) All plans/providers should be required to meet standards regarding telephone triage after business hours.

(5) Timely access applies to plans and to their delegated groups, associations, and contractors.

(6) The Department should adopt meaningful standards for measuring enrollee satisfaction.

(7) Plans must be required to afford timely access even in areas where there are recognized shortages of certain providers.

(8) Exceptions should be allowed only for true health care emergencies.

(9) There should be no "exemption" to timely access for plans offering advanced access, particularly without Departmental oversight.

(10) Any alternative standards must meet specific standards for a limited time period and be reviewed using a public process.

(11) The Department's regulation should not restrict litigation against a plan resulting from the plan's denial, delay or modification of a health care service if that denial, delay or modification resulted in substantial harm.

(12) Timely access to care should be reflected on the OPA Report Card.

APPLICANT's participation in the informal stakeholder process included comments provided by letter dated November 25, 2008. That submission contained approximately twelve comments, including expressions of support for the Department's return to regulations based on time-elapsed standards as the only measures that meet the statutory requirement. The submission contained comments to strengthen the regulatory requirements and oversight by the Department, and provided supporting argument and information.

(1) Timely access standards must apply to all health plans. The Department should not waive applicability to specialized plans.

(2) The Department's regulation should not restrict litigation against a plan caused by the plan's denial, delay or modification of a health care service if it resulted in substantial harm.

(3) Definitions should conform to statutory language and intent.

(4) Consumers should not have to make a choice between cultural and linguistic access to care and their right to timely access to care.

(5) Systems, policies, and procedures of quality assurance must actually demonstrate appropriate access to care.

(6) Flexibility in appointment times provided in the regulation (at section 1300.67.2.2(d)(2)) must be governed by clinical appropriateness and professionally recognized standards of practice.

(7) Each plan's annual survey should measure compliance in each of the plan's service areas.

(8) Any alternative standards must meet specific standards for a limited time period and be reviewed using a public process.

(9) Plan compliance with timely access standards should be measured in the plan's annual report to the Department in smaller geographic units than counties in the plan's service area and should be mapped to the plan's enrollees.

(10) The Department should evaluate a plan's compliance with timely access including what might be construed as efforts to evade the intent of the law.

(11) If the Department incorporates survey methodology, meaningful standards for measuring enrollee satisfaction must be adopted.

(12) Timely access to care should be reflected on the OPA Report Card.

Proceeding Control No. 2008-1579

By letter dated February 23, 2009, APPLICANT's staff presented written comments on the proposed regulation, signed by the Executive Director of APPLICANT. That submission contained approximately seventeen comments, including comments with recommendations requesting changes and supporting argument and information to assure that the intent of the Legislature is met.

(1) Timely access is fundamental to the Knox-Keene Act.

(2) Legislative intent found that lack of timely access often reflects broader problems, including lack of adequate provider panels, fiscal distress of a plan or provider, or shifts in the health care needs of a covered population.

(3) Time-elapsed standards – in all of the debate, discussions, hearings, meetings, workgroups, submissions, and other expressions of views, virtually the only standard for timely access that has been proposed has been time-elapsed standards, including same-day access which is

simply a briefer time period than the time-elapsed standard. Time-elapsed standards should serve as a minimum, with clinicians able to provide more timely care if clinically necessary.

(4) Economic impact of lack of timely access includes lost work-days, lost school-days, and lost productivity. Lack of timely access for triage, urgent care, primary care and specialty care contribute to avoidable emergency room use. Assuring timely access to clinically appropriate care can help to reduce the cost of care for insured populations.

(5) Urgent care – 48 hours is a long time to wait for a serious and imminent threat to the health of an enrollee. Opposition was expressed for the provision that permits urgent care to be delayed as long as 96 hours if prior authorization is required.

(6) Same day access – systems, policies, and procedures of quality assurance must actually demonstrate appropriate access to care. Verifying advanced access should include confirming that appointments are scheduled consistent with the definition of advanced access.

(7) Flexibility in appointment times and triage provided in section 1300.67.2.2(c)(5)&(9) of the regulation is appropriately governed by clinical appropriateness and professionally recognized standards of practice.

(8) Consumers should not have to make a choice between cultural and linguistic access to care and their right to timely access to care.

(9) Any alternative standards should be more appropriate for enrollees and be subject to public disclosure.

(10) Timely access standards must apply to all health plans, including specialized health plans.

(11) The regulations must apply to Medi-Cal and Healthy Families plans. Opposition was expressed for creating a separate tier of consumer protections for Medi-Cal and Healthy Families enrollees.

(12) PPOs and HMOs – timely access standards must apply to both. Opposition was expressed for separate standards.

(13) Plan compliance with timely access standards: interaction with geographic access and language access; compliance monitoring policies and procedures.

(14) Reliance on survey methodology – the survey instrument and methodology must be publicly available.

(15) Plan compliance with timely access standards: interaction with geographic access and language access; network adequacy.

(16) The Department should evaluate a plan's compliance with timely access including what might be construed as efforts to evade the intent of the law.

(17) Timely access to care should be reflected on the OPA Report Card.

By letter dated June 24, 2009, APPLICANT's staff presented written comments on the proposed regulation, signed by the Executive Director of APPLICANT. That submission contained approximately five comments, including expressions of support for certain provisions and presentation of analysis of hypothetical fact situations illustrating why the changes were needed.

(1) Regarding telephone triage, the change from 10 minutes to 30 minutes is too long. A period of 10 to 15 minutes is more reasonable and would be more likely to reduce inappropriate emergency room utilization. The relevant phone call is not the call to the doctor's office but the call from the doctor or the nurse to the consumer who is trying to decide whether or not to go to the emergency room.

(2) Regarding standards for timely access for services out of network, clinical appropriateness must prevail over the preferences of a consumer for a specific provider.

(3) Regarding administrative capacity of providers, a prior version of the regulations required that plans ensure that providers have administrative capacity to perform the necessary care in a timely manner.

(4) Regarding compliance monitoring of network adequacy, the regulation should reflect collection of data to better enable the Department to monitor compliance with geographic access and network adequacy.

(5) Regarding disclosure to consumers, it is essential that plans be required to notify consumers of timely access protections and of the availability of triage and screening in the evidence of coverage and annual communications to enrollees.

By letter dated August 7, 2009, APPLICANT's staff presented written comments on the proposed regulation, signed by the Executive Director of APPLICANT. That submission contained approximately one comment with a recommendation requesting change.

(1) The standard for urgent care should apply to "advanced access" as well in order to avoid a conflict between the timely access standard for 48 hours and the "advanced access" definition of the "same or next business day from the time an appointment is requested," which may be more than 48 hours if the appointment is requested on a Friday or on Wednesday before Thanksgiving.

By letter dated October 12, 2009, APPLICANT's staff presented written comments on the proposed regulation, signed by the Executive Director of APPLICANT. That submission contained approximately four comments with recommendations requesting changes.

(1) The strongest language should be used by the provider to document exceptions to timely access. The regulation should use the word "document" instead of "note" to encourage the level of detail required for sufficient specificity to assure that the delay granted in providing care is based on purely clinical considerations and to avoid delay that could have serious consequences for the patient.

(2) The screening and triage function should be performed by licensed medical professionals to avoid any possibility of adverse health consequences to patients as a result of delays or improper referrals that may result from even a limited role for unlicensed non-medical personnel in the medical screening process.

(3) Any alternative method of demonstrating network adequacy and measuring timely access should be open to scrutiny by consumers, advocates, and the public, as should the departmental review process of the plan's request. The use of general, non-quantitative, or soft measures of network adequacy has not historically resulted in a plan's ability to provide timely access to care. Consequently, strenuous opposition was provided against watering down the oversight and compliance language in the regulation to include exceptions and alternate mechanisms for proving compliance.

(4) In regard to the documentation requirements of the plan's provider network and enrollment, objection was made to the elimination of the map requirement because the map of the plan's provider network makes insufficiencies easily visible and more easily detected and overcome.

Of the February 23, 2009, June 24, 2009, August 7, 2009, and October 12, 2009, comments requesting changes, all were reviewed, some were accepted, some were declined, and some were neither accepted nor declined. The rulemaking action of Proceeding Control No. 2008-1579 resulted in the regulation being filed with the Secretary of State to become effective.

5.4. FINDING OF SUBSTANTIAL CONTRIBUTION

The Hearing Officer finds that participation by APPLICANT: (1) significantly assisted the Department in its deliberations by presenting relevant issues, evidence, and arguments that were helpful and seriously considered, and (2) resulted in more relevant, credible, and non-frivolous information being available to the Director to make her decision regarding the proposed adoption of 28 CCR §1300.67.2.2 than would have been available to the Director had APPLICANT not participated.

The Hearing Officer hereby determines that by its participation APPLICANT made a substantial contribution on behalf of consumers to the proceedings, to the Department in its deliberations, and as a whole, to the adoption of 28 CCR §1300.67.2.2.

The Hearing Officer finds that APPLICANT has made a Substantial Contribution, pursuant to 28 CCR § 1010(b)(8), to the timely access rulemaking proceeding.

6. REASONABLENESS OF HOURS AND COSTS AND MARKET RATE

Health and Safety Code section 1348.9 allows the Director to award reasonable advocacy and witness fees to any person or organization that demonstrates that the person or organization represents the interests of consumers and has made a substantial contribution on behalf of consumers to the adoption of a regulation.

6.1. FEES AND COSTS REQUESTED

APPLICANT billed the following time, hourly rates, and fees for its representatives.

Staff / Title	Hours	Rates	Fees
Health Care Policy Expert			
-- Work in 2004	14.5	$350.00	$5,075.00
-- Work in 2005	3.0	$360.00	$1,080.00
-- Work in 2006	26.0	$370.00	$9,620.00
-- Work in 2007	12.0	$380.00	$4,560.00
-- Work in 2008	80.25	$390.00	$31,297.50
-- Work in 2009	23.75	$390.00	$9,262.50
Executive Director & Health Care Policy Expert			
-- Work in 2004	7.25	$230.00	$1,667.50
-- Work in 2005	0.5	$240.00	$120.00
-- Work in 2006	2.5	$250.00	$625.00
-- Work in 2007	13.75	$260.00	$3,575.00
-- Work in 2008	31.5	$270.00	$8,505.00
-- Work in 2009	6.0	$270.00	$1,620.00
-- Work in 2010	1.0	$270.00	$270.00
Health Care Policy Expert			
-- Work in 2006	7.0	$370.00	$2,590.00
-- Work in 2007	44.0	$380.00	$16,720.00
-- Work in 2008	91.5	$390.00	$35,685.00
-- Work in 2009	23.5	$390.00	$9,165.00
-- Work in 2010	2.75	$390.00	$1,072.50
TOTAL FEES[11]	→		**$142,510.00**

APPLICANT did not claim or bill for any expenses or recoverable costs.

6.2. CONSIDERATIONS USED IN PUC'S INTERVENOR COMPENSATION PROGRAM

Reference to the Intervenor Compensation Program of the California Public Utilities Commission ("PUC") seems appropriate because it is similar to the Department's Consumer

[11] The time records submitted in APPLICANT's Application contained six computation errors due to rounding up. However, the Total amount did not contain the effect of the rounding.

Participation Program[12] and has an extensive history of awarding intervenor compensation and updating hourly rates used in computing awards of compensation to intervenors who make substantial contributions to PUC decisions.

In each proceeding before the PUC in which intervenors participate, the PUC issues a written opinion setting forth the decision regarding award of intervenor compensation. Therefore, the many PUC written decisions granting intervenor compensation provide a valuable source of guidelines to determine reasonableness and market value. Some of the common threads of the PUC decisions are summarized as follows.

In considering an intervenor organization's request for compensation, the PUC opinions:

a. Separately consider and approve the individual hourly rate of compensation for each of the intervenor's experts and advocates.[13]

b. Have awarded the same rate for an individual expert that was approved in a prior proceeding in the same year,[14] and have declined to approve a requested increase in hourly rate for an expert over the rate approved in a prior proceeding in the same year.[15]

c. Have awarded increases of three percent (3%) rounded to the nearest $5 over the prior year when increase in hourly rates is requested by the intervenor organization or where the hourly rate for an individual expert or advocate was approved in the prior year and an increase is considered warranted for the current year.[16] The PUC has consistently rejected requests for increases over 3%.[17]

d. Have stated that documentation of claimed hours by presenting a daily breakdown of hours accompanied by a brief description of each activity reasonably supported the claim for total hours.[18]

e. Have approved compensation for travel time at one-half the normal hourly rate.[19]

f. Have approved compensation for preparation of the intervenor organization's compensation request or compensation claim at one-half the normal hourly rate.[20] However,

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[12] The Legislative history behind the Department's Consumer Participation Program specifically referred to the PUC's program.

> "The Legislature finds and declares that consumer participation programs at the Public Utilities Commission and the Department of Insurance have been a cost-effective and successful means of encouraging consumer protection, expertise, and participation...." Stats 2002 C. 792 § 1 (SB 1092).

[13] PUC Decision (D.) 06-11-031 (November 30, 2006).
[14] D.06-11-031 (November 30, 2006).
[15] D.06-11-032 (November 30, 2006), pp. 10 – 11.
[16] D.06-11-031 (November 30, 2006), p. 11.
[17] D.06-11-031 (November 30, 2006), p. 11.
[18] D.06-11-031 (November 30, 2006), p. 10.
[19] D.06-11-031 (November 30, 2006); D.06-11-032 (November 30, 2006), p. 8, fn. 4.
[20] D.06-11-031 (November 30, 2006), p. 9, fn. 2; D.06-11-032 (November 30, 2006), p. 8, fn. 4.

administrative costs are considered non-compensable overheads, and therefore, the PUC has disallowed time charged by an intervenor's office manager for gathering expense data for the compensation claim.[21]

g. Have approved compensation for efforts that made a substantial contribution even where the PUC did not wholly adopt the intervenor's recommendations.[22]

h. Have approved payment of itemized direct expenses where the request shows "the miscellaneous expenses to be commensurate with the work performed," including costs for photocopying, FAX, Lexis research, postage, courier, overnight delivery, travel, and parking.[23]

i. Have reminded intervenors of the requirements for records and claim support, and that PUC staff may audit the records – for example:

> "We remind all intervenors that Commission staff may audit their records related to the award and that intervenors must make and retain adequate accounting and other documentation to support all claims for intervenor . compensation. [Intervenor's]... records should identify specific issues for which it requested compensation, the actual time spent by each employee or consultant, the applicable hourly rate, fees paid to consultants, and any other costs for which compensation was claimed."[24]

j. Have disallowed time where the "hours seem excessive" or the "proposal is not persuasive,"[25] and have changed or disallowed compensation amounts requested for the following reasons:[26] "Excessive hourly rate; arithmetic errors; failure to discount comp prep time [and travel time]; hours claimed after decision issued; ...administrative time not compensable; unproductive effort."

6.3. REASONABLENESS OF TIME BILLED

We must assess whether the hours claimed for the consumers' efforts that resulted in Substantial Contributions to the proceedings are reasonable by determining to what degree the hours and costs (if any costs are claimed) are related to the work performed and necessary for the Substantial Contribution.[27]

a. Billed Activities. APPLICANT billed for approximately 19 activities summarized as follows:

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[21] D.06-11-009 (November 9, 2006), p. 27.
[22] D.06-11-031 (November 30, 2006), p. 10.
[23] D.06-11-031 (November 30, 2006), p. 12; D.06-11-032 (November 30, 2006), pp. 14 – 15; D.06-11-009 (November 9, 2006), p. 32.
[24] D.06-11-031 (November 30, 2006), pp. 14 -15.
[25] D.06-11-032 (November 30, 2006), pp. 9 - 10.
[26] D.06-11-009 (November 9, 2006), Appendix p. 1.

(1) Review and analysis of the proposed regulation; preparation for, attend and testify at a noticed Public Hearing held on August 16, 2004, for a total of 7.0 hours.

(2) Preparation for and participation in meeting with Department managers and staff on September 13, 2004, regarding proposed regulation language, and prepare and edit written comments in a letter dated December 7, 2004, for submission to the Department, for a total of 14.75 hours.

(3) Preparation for and participation in a meeting with Department managers and staff on June 17, 2005, in regard to revision to the proposed regulation, for a total of 3.5 hours.

(4) Preparation and editing of draft comments in January 2006, on the proposed regulation for the next submission, for a total of 3.0 hours.

(5) Review documents, preparation for, attendance at, and participation in stakeholder meetings regarding the proposed regulation language, held in October and November 2006, for a total of 32.5 hours.

(6) Preparation for, attendance at, and present testimony at a Public Hearing held on March 5, 2007, regarding the proposed regulation, for a total of 14.0 hours.[28]

(7) Analysis of the proposed regulation and preparation of written comments submitted by letter dated March 5, 2007, for a total of 4.0 hours.

(8) Preparation for, attendance at, and present testimony at a Public Hearing held on September 18, 2007, regarding the proposed regulation, for a total of 16.25 hours.[29]

(9) Analysis of revisions to the proposed regulation and preparation of written comments submitted by letter dated September 21, 2007, for a total of 15.0 hours.

(10) Analysis of major revisions to the proposed regulation and preparation of written comments submitted by letter dated December 26, 2007, for a total of 16.25 hours.

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[27] See, e.g., PUC D.06-11-031 (November 30, 2006), p. 10; D.06-11-032 (November 30, 2006), p. 9; D.06-11-009 (November 9, 2006), p. 26.

[28] In addition to time billed for APPLICANT's Project Director and Health Care Policy Expert for presentation of testimony at the Public Hearing, time was billed by APPLICANT'S Health Care Policy Expert described as "attended DMHC public hearing…", with no indication of testifying, and the transcript of the hearing did not reflect appearance or testimony. Merely attending a hearing (without testifying or otherwise contributing) does not evidence a substantial contribution to the proceeding. However, it may be inferred that attendance at the hearing may have been intended to obtain information and take notes regarding the testimony of other parties, particularly health plans and providers, in order to better prepare written arguments for post-hearing submission. Applying this inference, time billed for attending the hearing was allowed.

[29] APPLICANT's Health Care Policy Expert and APPLICANT's Executive Director billed for time for attending the hearing without testifying. Due to the complexity and contentiousness of the proceeding, the same inference may be drawn regarding collecting information to better enable future written submission(s). *Id.*

(11) Attend and participate in meetings and conference calls with Department leadership and consumers in light of the OAL rejection of the proposed regulation, and preparation of comments for submission to the Department, for a total of 30.75 hours.

(12) Attend and participate in Department workshop meetings in June through August 2008, used to assist in drafting new proposed regulation language and address issues, including preparation of comments, review of other stakeholders' comments, and prepare further written comments, for a total of 60.0 hours.

(13) Preparation of written comments in comment letter dated August 22, 2008, regarding the proposed regulation language, for a total of 42.75 hours.

(14) Attend and participate in Department sponsored stakeholder workshops in September and October 2008, regarding specific timely access issues numbered 1 – 7, for a total of 37.5 hours.

(15) Research and draft comments for letter dated November 25, 2008, for a total of 27.0 hours.

(16) Research and draft comments for letter dated February 23, 2009, for a total of 35.75 hours.

(17) Participate in conference calls with Department leadership and preparation of comments in a letter dated June 24, 2009, for a total of 8.25 hours.

(18) Research and draft written comments in a letter dated August 7, 2009, on the revised language of the regulation, for a total of 1.5 hours.

(19) Research and draft written comments in a letter dated October 12, 2009, on the revised language of the regulation, for a total of 6.0 hours.

b. Adjustments. The time billed appears reasonable except for the following:

(1) Time for attending a non-existent public hearing. APPLICANT billed 2.0 hours for services described as "Attended DMHC public hearing on timely access to care" on August 13, 2007, by APPLICANT's Health Care Policy Expert. Although a public hearing was scheduled and noticed for August 13, 2007, by notice dated August 8, 2007, the Department rescheduled the Public Hearing to September 18, 2007. A public hearing was not held on August 13, 2007. Therefore, APPLICANT's Health Care Policy Expert could not have attended. Furthermore, merely attending a hearing (without testifying, otherwise contributing, or without anything more) does not evidence a substantial contribution to the proceeding. Accordingly, the 2.0 hours of time billed for services on August 13, 2007, are disallowed.

(2) Time for services after the proposed regulation was adopted.[30] Compensation may be awarded "... for advocacy fees and witness fees in any proceeding relating to the adoption of any regulation ...." (28 CCR § 1010(b)(2), (5) and (8)) (Emphasis added). The final regulation was submitted to the OAL on November 3, 2009, was submitted to the Secretary of State on December 18, 2009, and became effective on January 17, 2010. One hour billed for services of APPLICANT's Executive Director and Health Care Policy Expert is disallowed because it was billed for services to review and summarize final analysis and draft public commentary on January 20, 2010, which was after the regulation was adopted and became effective.

(3) Time for services not part of the contribution to the Department. The following "regulatory updates" were not presented to the Department, and therefore not helpful because they did not present relevant issues, evidence, or arguments relating to the adoption of the timely access regulation (28 CCR § 1010(b)(2), (5) and (8)). Time billed for APPLICANT's Project Director and Health Care Policy Expert was described as "prepare regulatory update," including:

> 3/9/2007 Prepare regulatory update on pending DMHC timely access regulations -- 2.25 hours;
> 9/20/2007 Prepare regulatory update on pending DMHC timely access regulations -- 2.25 hours;
> 2/28/2008 Prepare regulatory update on pending DMHC timely access regulations -- 1.5 hours;
> 12/9/2008 Prepare regulatory update on three pending DMHC regulations -- 0.25 hours (emphasis added);
> 1/6/2009 Prepare regulatory update on final DMHC timely access regulations --1.25 hours;
> 10/23/2009 Prepare regulatory update on pending DMHC timely access regulations -- 0.5 hours;
> 11/19/2009 Prepare regulatory update on pending DMHC timely access regulations -- 0.75 hours;
> 12/21/2009 Prepare regulatory update on final DMHC timely access regulations -- 0.75 hours;
> 12/22/2009 Prepare regulatory update on final DMHC timely access regulations -- 2.0 hours; and
> 1/6/2010 Prepare regulatory update on final DMHC timely access regulations -- 2.75 hours.

The record of the proceeding does not reflect filing or submission to the Department of any such "regulatory updates," and therefore, they do not appear to have presented relevant issues, evidence, or arguments relating to the adoption of the timely access regulation. The regulatory updates may have been prepared for APPLICANT's internal purposes or for use in publications or

[30] See, e.g., PUC D.06-11-009 (November 9, 2006), pp. 26-27 (billed hours disallowed that came *after* the decision was decided).

website updating, but there does not appear to be any evidence of submission to the Department for the Department's use in preparing the regulation. Accordingly, time for preparing the regulatory updates may be on the order of administrative time[31] which is not part of the substantial contribution to the Department's proceeding. In addition, four of the time entries were for dates after the regulation was submitted to the OAL; two of those were for dates after the regulation was submitted to the Secretary of State, and one was for a date after the regulation became effective. Therefore, 14.25 hours of the time billed for preparation of regulatory updates by the Project Director and Health Care Policy Expert are disallowed.

(4) Time billed at rates in excess of Market Rate. Time billed for APPLICANT's Policy Expert for services in 2004 and 2005 exceeded Market Rate and is adjusted to be within market rate, as described in Paragraph 6.8, *infra.*

c. Finding. The Hearing Officer hereby finds that, as adjusted, the time billed is related to the work performed, necessary for the substantial contributions made, and reasonable for the advocacy and witness services performed and work product produced.

6.4. MARKET RATE

Public interest attorneys are entitled to request the prevailing market rates of private attorneys of comparable skill, qualifications and experience. (*Serrano v. Unruh* ("*Serrano IV*") (1982) 32 Cal.3d 621.). APPLICANT is entitled to be compensated for Advocacy Fees and Witness Fees at hourly rates that reflect Market Rate for services. Advocacy Fees and Witness Fees cannot exceed Market Rate, as defined in the Regulation. 28 CCR §§ 1010(b)(1), (3) and (10). "Market Rate" is defined at 28 CCR section 1010(b)(3) as follows:

> "'Market Rate' means, with respect to advocacy and witness fees, the prevailing rate for comparable services in the private sector in the Los Angeles and San Francisco Bay Areas at the time of the Director's decision awarding compensation for attorney advocates, non-attorney advocates, or experts with similar experience, skill and ability."

6.5. HOURLY RATES THAT REFLECT "MARKET RATE"

The Hearing Officer finds that hourly rates for services provided in a statewide proceeding or proceeding of a state agency having statewide jurisdiction and effect (such as proceedings of the PUC, see *infra*) are essentially equivalent to hourly rates for "comparable services in the private sector in the Los Angeles and San Francisco Bay Areas," as required by 28 CCR § 1010, subsection (b)(3).

Accordingly, we must take into consideration whether the claimed fees and costs (if any) are comparable to the market rates paid to experts and advocates having comparable training and

[31] D 06-03-013 (November 9, 2006), p.27 ("Administrative costs are considered non-compensable overheads.").

experience and offering similar services.[32] In order to determine Market Rate, we must look to available data inside and outside the Department.

6.6. APPLICANT'S JUSTIFICATION FOR RATES BILLED

In support of the hourly fee rates requested, APPLICANT submitted experience and biographical information regarding the persons providing services and reference to [PUC] billing rate classifications: "Non-Attorney Expert 13+ years" and "Non-Attorney Expert 7 – 12 years." In addition, the end of APPLICANT's documentation of time records contained the following:

> "Hourly Rate Determinations are based on past award amounts and the PUC adopted ranges for non-attorney experts."
>
> "The billed hourly rate was increased annually by 3% COLA from year 2004 through 2008."
> "No COLA increase was included for 2008 – 2010."
> [Plus the PUC rates for non-attorney experts within three tiers of experience for 2006 -2008.]

6.7. HOURLY RATE DETERMINATIONS UNDER THE PUC PROGRAM

Until PUC Decision R.04-10-010 in 2004, the PUC "set hourly rates piecemeal"[33] for intervenors – i.e., "... for each proceeding, each intervenor, and indeed each appearance by a particular representative of an intervenor, ...[the PUC] might revisit the reasonableness of that representative's hourly rate."[34] The PUC recognized the need for coordination by establishing, through periodic rulemakings, the rates to be paid to all intervenors' representatives for work done in specified time periods.[35] The first such rulemaking was R.04-10-010, D.05-11-031, which set certain guidelines, recognized that hourly rates had stabilized, and determined that the PUC would not authorize a general increase to intervenor hourly rates for work performed in 2005.[36]

In an Interim Opinion on Updating Hourly Rates,[37] the PUC adopted a three percent (3%) cost-of-living adjustment (COLA) for work performed in calendar year 2006, adopted an additional 3% COLA for work performed in 2007, and established effective with 2007 work three rate ranges for non-attorney experts based on levels of experience, similar to the five levels already established for attorneys.[38] The three levels for non-attorney experts are: 0-6 years; 7-12 years; and 13-plus years. In so doing, the PUC found that:

> "...basing expert rates on levels of experience, similar to the levels established for attorneys, will better ensure that an expert's given rate is within the market rates paid to persons of comparable training and

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[32] See, e.g., PUC D.06-11-031 (November 30, 2006), p. 10; D.06-11-032 (November 30, 2006), p. 10.
[33] PUC Order Instituting Rulemaking R.06-08-019 (August 24, 2006), p. 2.
[34] *Id.*
[35] *Id.*
[36] *Id.* at pp. 2-3.
[37] D.07-01-009 (January 11, 2007) (part of Rulemaking R.06-08-019).
[38] *Id.* at pp. 1, 3-4.

> experience. However, in no event should the rate requested by an intervenor exceed the rate billed to that intervenor by any outside consultant it hires, even if the consultant's billed rate is below the floor for a given experience level. ...[I]ntervenors must disclose the credentials of their representatives in order to justify the requested rates.[39] (Emphasis added).

The following table shows the PUC's adopted ranges for work performed by intervenor representatives in 2006, 2007, 2008 and 2009. The rate ranges for attorneys and non-attorney experts are based on levels of applicable experience.

Hourly Intervenor Rate Ranges for 2006, 2007, 2008[40] and 2009

(2006 rates = rates adopted in D.05-11-031 + 3%, rounded to nearest $5)
(2007 rates = rates adopted for 2006 in D.07-01-009 + 3%, rounded to nearest $5)
(2008 rates = rates adopted for 2007 + 3%, rounded to nearest $5)
(2009 rates = 2008 rates adopted for 2009 in Resolution ALJ-235)

Years of Experience	2006 Range	2007 Range	2008 and 2009[41] Range
Attorneys:			
0 - 2	$140 - $195	$145 - $200	$150 - $205
3 - 4	$190 - $225	$195 - $230	$200 - $235
5 - 7	$260 - $280	$270 - $290	$280 - $300
8 - 12	$280 - $335	$290 - $345	$300 - $355
13+	$280 - $505	$290 - $520	$300 - $535
Experts:			
0 - 6		$120 - $180	$125 - $185
7 - 12		$150 - $260	$155 - $270
13+		$150 - $380	$155 - $390
All years	$115 - $370		

Note: The rates intervenors request for the use of outside consultants may not exceed the rates billed to the intervenors by the consultants, even if the consultants' rates are below the floor for any given experience level.

The PUC decided to continue to update hourly rates annually on a calendar year basis.[42] The PUC based its 3% COLA adjustments on the Social Security Administration's COLA, which is

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[39] *Id.* at p. 5.
[40] D.08-04-010 (April 10, 2008) (part of Rulemaking 06-08-019) at p. 5.
[41] For work performed in 2009, the PUC ordered that intervenors are not authorized an hourly rate COLA, and hourly rate ranges adopted for 2008 remain in effect. Resolution ALJ-235 (March 12, 2009) at pp. 2-4.
[42] D.07-01-009 (January 11, 2007) at p. 9.

released annually in late fall, and reliance thereon would be consistent with a calendar year adjustment of hourly rates.[43]

In 2008, the PUC found it reasonable to adopt another 3% COLA for intervenor rates for work performed in 2008.[44] That increase is primarily based on various federal inflation indexes, such as the Social Security Administration's COLA and Bureau of Labor Statistics data for consumer prices and wages.[45] In its 2008 Decision and for future reference, the PUC found that a COLA adjustment should be authorized, by future PUC Resolution, for work performed in 2009, and in subsequent years in the absence of a market rate study, to be effective on January 1 of each year.[46] However, a COLA would not necessarily be authorized. By Resolution ALJ-235 (March 12, 2009), the PUC ordered that intervenors are not authorized an hourly rate COLA for work performed in 2009, and hourly rate ranges adopted for 2008 would remain in effect.

6.8. DETERMINATION OF MARKET VALUE HOURLY RATE

Fees claimed may be adjusted to reflect Market Rate. "The hearing officer shall issue a written decision that ... shall determine the amount of compensation to be paid, which may be all or part of the amount claimed." 28 CCR § 1010(e)(7). APPLICANT claims advocacy and witness fees for: one Health Care Policy Expert; one Executive Director and Health Care Policy Expert; and one Project Director and Health Care Policy Expert.

For work performed by APPLICANT's Health Care Policy Expert ("Policy Expert"), APPLICANT claims advocacy and witness fees at hourly rates of $350.00 for services in 2004, $360.00 for services in 2005, $370.00 for services in 2006, $380.00 for services in 2007, and $390.00 for services in 2008 and 2009. At the time of the work for which the claim is made and according to the biographical information submitted, APPLICANT's Policy Expert had a Ph.D. in political science from the University of California at Berkeley and had over 30 years of experience working in the California Legislature, California Administrations, and for various interest groups, including APPLICANT, the California Nurses Association, the California Physicians Alliance, and the California Manufacturers Association. The PUC did not have adopted non-attorney hourly rate ranges for 2004 and 2005; however, a PUC Decision[47] set forth individually adopted non-attorney rates ranging from $150 to $215 for non-attorney experts with 12 to 16 years of experience, during 2003-2005. The PUC's adopted hourly non-attorney intervenor rate range for 2006 is $115 - $370

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[43] *Id.* at pp. 4 and 11.
[44] D.08-04-010 (April 10, 2008) at pp. 4 and 24.
[45] *Id.* In reviewing available data, the PUC found no index that specifically targets rates for services by regulatory professionals (attorneys, engineers, economists, scientists, etc.), and the PUC's "findings are weighted heavily to SSA COLA and similar data." *Id.* at p. 4.
[46] D.08-04-010 (April 10, 2008) at pp. 24 -25.

without breakdown by years of experience. For non-attorney experts with 13 and over years of experience, the PUC range for 2007 is $150 - $380, and the range for 2008 and 2009 is $155 - $390. The highest of the PUC's rates for non-attorney experts for 2006 is $370, for 2007 is $380, and for 2008 and 2009 is $390. However, the highest of the individually awarded PUC rates (for 16 years of experience) for 2003 was $215, and the $350.00 hourly rate claimed for 2004 is slightly more than 94 percent of the highest of the rates adopted in PUC's rate range for non-attorney experts for services in 2006 -- i.e., illustrated by reducing PUC's highest rate for 2006 ($370) by 3 percent per year to 2005 ($370 x .97 = $358.90) and 2004 ($358.90 x .97 = $348.13). Therefore, it appears that the $350.00 hourly rate claimed for 2004 and the $360.00 hourly rate claimed for 2005 exceed Market Rate as defined in 28 CCR § 1010(b) construed in accordance with PUC rate ranges, and therefore will be adjusted. It also appears that the $370.00 hourly rate claimed for 2006, the $380.00 hourly rate claimed for 2007, and the $390.00 hourly rate claimed for 2008 and 2009 by APPLICANT do not exceed Market Rate as defined in 28 CCR § 1010(b). Regarding services provided by APPLICANT's Policy Expert, the Hearing Officer finds that $348.00 per hour for services provided in 2004, $358.00 per hour for services provided in 2005, $370.00 per hour for services provided in 2006, $380.00 per hour for services provided in 2007, and $390.00 per hour for services provided in 2008 and 2009 do not exceed Market Rate for the services provided in 2004, 2005, 2006, 2007, 2008 and 2009.

For work performed by APPLICANT's Executive Director & Health Care Policy Expert ("Executive Director"), APPLICANT claims advocacy and witness fees at an hourly rate of $230.00 for services in 2004, $240.00 for services in 2005, $250.00 for services in 2006, $260.00 for services in 2007, and $270.00 for services in 2008, 2009 and 2010. At the time of the work for which the claim is made and according to the biographical information submitted, APPLICANT's Executive Director had: approximately two to eight years of experience (2002 – 2010) as Executive Director of APPLICANT; several years of experience as Program Director of New Jersey Citizen Action; and experience at the Center for Media Education in Washington, DC; for a total of approximately 7 to 12 years[48] of relevant experience; and a BA degree in English and Sociology from Amherst College in Amherst, MA. The PUC did not have adopted non-attorney hourly rate ranges for 2004 and 2005. However, a PUC Decision[49] set forth individually adopted non-attorney rates ranging from $120 to $180 for non-attorney experts with 7 to 12 years of experience, during 2003-2005. The PUC's

[47] D.06-11-032 (November 30, 2006), pp. 11 – 12.
[48] The biographical information provided by APPLICANT does not specify the length term for each of the employment experiences.
[49] D.06-11-032 (November 30, 2006), pp. 11 – 12.

adopted hourly non-attorney intervenor rate range for 2006 is $115 - $370 without breakdown by years of experience. For non-attorney experts with 7 to 12 years of experience, the PUC range for 2007 is $150 - $260, and the range for 2008 and 2009 is $155 - $270. The $230.00 hourly rate claimed for 2004 is slightly more than 94 percent of the highest of the rates adopted in PUC's rate range for non-attorney experts for services in 2007 -- i.e., illustrated by reducing PUC's highest rate for 2007 ($260) by six percent (3 percent per year for 2005 and 2006) ($260 x .94 = $244.40 for 2005) and an additional three percent per year for 2004 ($244.40 x .97 = $237.07). Therefore, it appears that the $230.00 hourly rate claimed for 2004, the $240.00 hourly rate claimed for 2005, the $250.00 hourly rate claimed for 2006,[50] the $260.00 hourly rate claimed for 2007, and the $270.00 hourly rate claimed for 2008, 2009 and 2010 by APPLICANT do not exceed "Market Rate" as defined in 28 CCR § 1010(b). Regarding services provided by APPLICANT's Executive Director & Health Care Policy Expert, the Hearing Officer finds that $230.00 per hour for services provided in 2004, $240.00 per hour for services provided in 2005, $250.00 per hour for services provided in 2006, $260.00 per hour for services provided in 2007, and $270.00 per hour for services provided in 2008, 2009 and 2010 do not exceed Market Rate for the services provided in 2004, 2005, 2006, 2007, 2008, 2009 and 2010.[51]

For work performed by APPLICANT's Project Director and Health Care Policy Expert ("Project Director"), APPLICANT claims advocacy and witness fees at an hourly rates of $370.00 for services in 2006, $380.00 for services in 2007, and $390.00 for services in 2008, 2009 and 2010. At the time of the work for which the claim is made and according to the biographical information submitted, APPLICANT's Project Director had a B.A. degree in psychology from the University of Redlands, had approximately 12 years (1993 – 2005) of experience with the Centers for Medicare and Medicaid Services (CMS), including several years as the Region IX Administrator for CMS, had several years of administrative experience with the Social Security Administration, and one to four years (January 2006 – present) of experience representing consumers as Project Director with APPLICANT. The PUC's adopted hourly non-attorney intervenor rate range for 2006 is $115 - $370 without breakdown by years of experience. For non-attorney experts with 13 or more years of experience, the PUC rate range for 2007 is $150 - $380, and the range for 2008 and 2009 is $155 -

[50] In a previous Decision (DMHC Decision 07-07-01), APPLICANT was awarded advocacy and witness fees at the hourly rate of $250.00 for services in 2006 provided by APPLICANT's Executive Director.

[51] However, compensation for services provided in 2010 was disallowed because the services were provided after the proceeding had ended and the regulation had become effective. See Paragraph 6.3, b(2), *supra*.

$390. Therefore, it appears that the $370.00 hourly rate[52] claimed by APPLICANT for services provided by APPLICANT's Project Director in 2006, the $380.00 hourly rate claimed for 2007, and the $390.00 hourly rate claimed for 2008, 2009 and 2010 by APPLICANT do not exceed "Market Rate" as defined in 28 CCR § 1010(b). Regarding services provided by APPLICANT's Project Director & Health Care Policy Expert, the Hearing Officer finds that $370.00 per hour for services provided in 2006, $380.00 per hour for services provided in 2007, and $390.00 per hour for services provided in 2008, 2009 and 2010 do not exceed Market Rate for the services provided in 2006, 2007, 2008, 2009 and 2010.[53]

Based on the information and documentation provided by APPLICANT, the Hearing Officer did not consider it necessary to audit the records and books of the APPLICANT to verify the basis for the amounts claimed in seeking the award. 28 CCR § 1010(e)(6).

7. AWARD

APPLICANT is awarded Advocacy and Witness Fees as follows:

Staff / Title	Hours	Rates	Fees
Health Care Policy Expert			
-- Work in 2004	14.5	$348.00	$5,046.00
-- Work in 2005	3.0	$358.00	$1,074.00
-- Work in 2006	26.0	$370.00	$9,620.00
-- Work in 2007	10.0	$380.00	$3,800.00
-- Work in 2008	80.25	$390.00	$31,297.50
-- Work in 2009	23.75	$390.00	$9,262.50
Executive Director & Health Care Policy Expert			
-- Work in 2004	7.25	$230.00	$1,667.50
-- Work in 2005	0.5	$240.00	$120.00
-- Work in 2006	2.5	$250.00	$625.00
-- Work in 2007	13.75	$260.00	$3,575.00
-- Work in 2008	31.5	$270.00	$8,505.00
-- Work in 2009	6.0	$270.00	$1,620.00
Project Director & Health Care Policy Expert			
-- Work in 2006	7.0	$370.00	$2,590.00
-- Work in 2007	39.5	$380.00	$15,010.00
-- Work in 2008	89.75	$390.00	$35,002.50
-- Work in 2009	18.25	$390.00	$7,117.50
TOTAL FEES	-	-	**$135,932.50**

[52] In two previous Decisions (DMHC Decision 07-07-01 01and Decision in Proceeding Control No. 2002-0019), APPLICANT was awarded advocacy and witness fees at the hourly rate of $370 for services in 2006 provided by APPLICANT's Project Director.

8. ASSIGNMENT OF PROCEEDING

This proceeding was and is assigned to Stephen A. Hansen, Staff Counsel III, as Hearing Officer.

FINDINGS OF FACT

1. APPLICANT has satisfied all the procedural requirements necessary to claim compensation in this proceeding.

2. APPLICANT made substantial contributions to Proceeding Control Nos. 2002-0018, 2005-0203 and 2008-1579 as described herein.

3. APPLICANT requested hourly rates for its representatives that, as adjusted herein, are reasonable when compared to market rates for persons with similar training and experience.

4. The total reasonable compensation for APPLICANT is $135,932.50.

CONCLUSIONS OF LAW

1. APPLICANT has fulfilled the requirements of Health and Safety Code § 1348.9 and 28 CCR § 1010, which govern awards of advocacy and witness compensation, and is entitled to such compensation, as adjusted herein, incurred in making substantial contributions to Proceeding Control Nos. 2002-0018, 2005-0203 and 2008-1579 and 28 CCR § 1300.67.2.2.

2. APPLICANT should be awarded $135,932.50 for its contribution to Proceeding Control Nos. 2002-0018, 2005-0203 and 2008-1579 and 28 CCR § 1300.67.2.2.

AWARD ORDER

1. Health Access of California, a California corporation, is hereby awarded $135,932.50 as compensation for its substantial contribution to the Timely Access regulatory Proceeding Control Nos. 2002-0018, 2005-0203 and 2008-1579 and to 28 CCR § 1300.67.2.2.

2. Payment shall be made within thirty (30) days of the effective date of this decision.

3. This decision is effective thirty (30) days after posting of this decision on the Department's website. 28 CCR § 1010(e)(7) and (8).

Dated: June 22, 2010

Original Signed by:

STEPHEN A. HANSEN
Hearing Officer
Department of Managed Health Care

[53] However, compensation for services provided in 2010 was disallowed as explained in Paragraph 6.3, b, *supra*.